Referral for Inpatient Forensic Evaluation

Receiving Facility: _____
Referring Facility: _____

Date of Referral: _____/_____/_____ Date of OP Evaluation: _____/ _____/ _____

Name of Service Recipient: _____

Social Security Number: ____/_____/_____ D.O.B.: _____/_____/_____

Charges: _____ Docket/Booking # _____
_____ DCS custody (if juvenile) _____ Y ____ N

Date of Alleged Crime: ____/_____/_____ Current Location/Placement: _____

County:_____ Prosecutor: _____

Judge: _____ Defense Attorney: _____

Clinical Information:

List All Interventions Used to Prevent Referral: □ Malingering Exam □ Medication Adjustments
□ Contacted Attorney(s) □ Competency Training □ Psychological Testing (specify) _____

□ Other (specify) _____

Reason for Referral: (Specify Clinical Rationale - Do Not State "For Forensic Evaluation")

_____

_____

If Referred to FSP (rationale): _____

_____

Current Medications: _____ _____
_____ _____

Current and/or Previous Mental Health Treatment: ___ Yes ___ No Facility: _____

Medical Concerns: (list) _____

Date of Phone Contact with the Receiving Forensic Coordinator: _____/_____/_____

Name of Person Making Referral: _____

Phone Number of Person Making Referral: _____

Information Included: ___ CMHC Evaluation ____ Military Records _____ Other: _____
____ Jail/Court Records ____ School Records _____
____ Attorney Records ____ Employment Records _____

____ Medical Records ____ A & D Records